

Reg. Dist. No. 96

3024

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/58

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03012

Reg. Dist. No.

3025

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital DOA</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Barton</u>		4. DATE OF DEATH Month Day Year <u>March 15 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26, 1916</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Barton</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Barton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>227-24-3232</u>	
17. INFORMANT Address <u>Mrs Walter Barton North East, Rd, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		DATE SIGNED <u>March 16, 1959</u>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 17, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P. Grant</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	
ADDRESS <u>North East, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEPT.

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

MADEIRA, J. DOMINGOS
1001 E. BERRY ST. (BETWEEN 11th & 12th)
ST. LOUIS, MO.

<input type="checkbox"/> Cause of death	<input type="checkbox"/> Immediate cause	<input type="checkbox"/> Underlying cause	<input type="checkbox"/> Contributing cause
<input type="checkbox"/> Disease	<input type="checkbox"/> Injury	<input type="checkbox"/> Poison	<input type="checkbox"/> Other
<input type="checkbox"/> Heart	<input type="checkbox"/> Lungs	<input type="checkbox"/> Stomach	<input type="checkbox"/> Kidneys
<input type="checkbox"/> Liver	<input type="checkbox"/> Spleen	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Intestines	<input type="checkbox"/> Bladder	<input type="checkbox"/> Uterus	<input type="checkbox"/> Vagina
<input type="checkbox"/> Testes	<input type="checkbox"/> Prostate	<input type="checkbox"/> Penis	<input type="checkbox"/> Scrotum
<input type="checkbox"/> Skin	<input type="checkbox"/> Bones	<input type="checkbox"/> Muscles	<input type="checkbox"/> Nerves
<input type="checkbox"/> Brain	<input type="checkbox"/> Spinal cord	<input type="checkbox"/> Nerves	<input type="checkbox"/> Blood vessels
<input type="checkbox"/> Blood	<input type="checkbox"/> Lymphatics	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Reproductive
<input type="checkbox"/> Immune	<input type="checkbox"/> Metabolic	<input type="checkbox"/> Nutritional	<input type="checkbox"/> Environmental
<input type="checkbox"/> Infectious	<input type="checkbox"/> Parasitic	<input type="checkbox"/> Neoplastic	<input type="checkbox"/> Degenerative
<input type="checkbox"/> Traumatic	<input type="checkbox"/> Toxic	<input type="checkbox"/> Iatrogenic	<input type="checkbox"/> Idiopathic

CERTIFICATE OF DEATH

Reg. Dist. No.

3026

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun (Rural)		c. LENGTH OF STAY IN 1b 25 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun (Rural)		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irvin Middle Roscoe Last Basham						4. DATE OF DEATH Month March Day 20 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1901		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Floyd, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Hatcher Basham						14. MOTHER'S MAIDEN NAME Martha Ridinger					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-36-0734		INFORMANT Mrs. Roscoe Basham				Address Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Myocardial infarction DUE TO Myocardial infarction (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 2, 1954 , to March 20, 1959 , that I last saw the deceased alive on March 20, 1959 , and that death occurred at 6:30 AM , from the causes and on the date stated above.											
ACTUAL SIGNATURE [Signature]						ADDRESS (Street, city or town, state) Port Deposit, Md.					
PHYSICIAN'S NAME (Type) [Signature]						DATE 3-21-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/23/59		22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery				22d. LOCATION (City, town, or county) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]						ADDRESS Rising Sun Md.		24a. REC'D BY REGISTRAR DATE MAR 24 59		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Page 1
Newland

State and (Newland) 20 Year - State and (Newland)

May 22, 1901 27
Newland

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CERTIFICATE OF DEATH

Reg. Dist. No.

3027

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 35 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route 7	
3. NAME OF DECEASED (Type or print) First Francis Middle Davis Last Bounds		4. DATE OF DEATH Month 3 Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1900
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineering Aid		10b. KIND OF BUSINESS OR INDUSTRY Aberdeen P.G.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Rev. George W. Bounds		14. MOTHER'S MAIDEN NAME Minnie Harvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-07-7811	
17. INFORMANT Nellie G. Bounds, Perryville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Med. hist. no. ch. test. to Brain 164 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Hypertens. Concl. Vascul. Dis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Months 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-22 , 19 51 , to 3-14 , 19 59 , that I last saw the deceased alive on 3-14 , 19 59 , and that death occurred at 7:54 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.H. Richards Jr.		DATE SIGNED 3-14-59	
PHYSICIAN'S NAME (Type) G.H. Richards Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-17-1959	22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03015

3028

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRIETTA Middle BROWN Last BROWN		4. DATE OF DEATH Month March Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October, 4, 1870
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Anderson		14. MOTHER'S MAIDEN NAME Henrietta Registrar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far advanced Senility + generalized arteriosclerosis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 1 19 59 , to 12 Mar 19 59 , that I last saw the deceased alive on 12 Mar 19 59 , and that death occurred at 11 30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Chenkin M.D.		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 16 Mar 59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March, 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.	22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Holloway		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
ADDRESS Wellington Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Fenn	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN A. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1965</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1965</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>JOHN A. SMITH</u></p>		<p>14. Address of informant: <u>NEW YORK</u></p>	
<p>15. Name of informant: <u>JOHN A. SMITH</u></p>		<p>16. Address of informant: <u>NEW YORK</u></p>	
<p>17. Name of informant: <u>JOHN A. SMITH</u></p>		<p>18. Address of informant: <u>NEW YORK</u></p>	
<p>19. Name of informant: <u>JOHN A. SMITH</u></p>		<p>20. Address of informant: <u>NEW YORK</u></p>	
<p>21. Name of informant: <u>JOHN A. SMITH</u></p>		<p>22. Address of informant: <u>NEW YORK</u></p>	
<p>23. Name of informant: <u>JOHN A. SMITH</u></p>		<p>24. Address of informant: <u>NEW YORK</u></p>	
<p>25. Name of informant: <u>JOHN A. SMITH</u></p>		<p>26. Address of informant: <u>NEW YORK</u></p>	
<p>27. Name of informant: <u>JOHN A. SMITH</u></p>		<p>28. Address of informant: <u>NEW YORK</u></p>	
<p>29. Name of informant: <u>JOHN A. SMITH</u></p>		<p>30. Address of informant: <u>NEW YORK</u></p>	
<p>31. Name of informant: <u>JOHN A. SMITH</u></p>		<p>32. Address of informant: <u>NEW YORK</u></p>	
<p>33. Name of informant: <u>JOHN A. SMITH</u></p>		<p>34. Address of informant: <u>NEW YORK</u></p>	
<p>35. Name of informant: <u>JOHN A. SMITH</u></p>		<p>36. Address of informant: <u>NEW YORK</u></p>	
<p>37. Name of informant: <u>JOHN A. SMITH</u></p>		<p>38. Address of informant: <u>NEW YORK</u></p>	
<p>39. Name of informant: <u>JOHN A. SMITH</u></p>		<p>40. Address of informant: <u>NEW YORK</u></p>	
<p>41. Name of informant: <u>JOHN A. SMITH</u></p>		<p>42. Address of informant: <u>NEW YORK</u></p>	
<p>43. Name of informant: <u>JOHN A. SMITH</u></p>		<p>44. Address of informant: <u>NEW YORK</u></p>	
<p>45. Name of informant: <u>JOHN A. SMITH</u></p>		<p>46. Address of informant: <u>NEW YORK</u></p>	
<p>47. Name of informant: <u>JOHN A. SMITH</u></p>		<p>48. Address of informant: <u>NEW YORK</u></p>	
<p>49. Name of informant: <u>JOHN A. SMITH</u></p>		<p>50. Address of informant: <u>NEW YORK</u></p>	
<p>51. Name of informant: <u>JOHN A. SMITH</u></p>		<p>52. Address of informant: <u>NEW YORK</u></p>	
<p>53. Name of informant: <u>JOHN A. SMITH</u></p>		<p>54. Address of informant: <u>NEW YORK</u></p>	
<p>55. Name of informant: <u>JOHN A. SMITH</u></p>		<p>56. Address of informant: <u>NEW YORK</u></p>	
<p>57. Name of informant: <u>JOHN A. SMITH</u></p>		<p>58. Address of informant: <u>NEW YORK</u></p>	
<p>59. Name of informant: <u>JOHN A. SMITH</u></p>		<p>60. Address of informant: <u>NEW YORK</u></p>	
<p>61. Name of informant: <u>JOHN A. SMITH</u></p>		<p>62. Address of informant: <u>NEW YORK</u></p>	
<p>63. Name of informant: <u>JOHN A. SMITH</u></p>		<p>64. Address of informant: <u>NEW YORK</u></p>	
<p>65. Name of informant: <u>JOHN A. SMITH</u></p>		<p>66. Address of informant: <u>NEW YORK</u></p>	
<p>67. Name of informant: <u>JOHN A. SMITH</u></p>		<p>68. Address of informant: <u>NEW YORK</u></p>	
<p>69. Name of informant: <u>JOHN A. SMITH</u></p>		<p>70. Address of informant: <u>NEW YORK</u></p>	
<p>71. Name of informant: <u>JOHN A. SMITH</u></p>		<p>72. Address of informant: <u>NEW YORK</u></p>	
<p>73. Name of informant: <u>JOHN A. SMITH</u></p>		<p>74. Address of informant: <u>NEW YORK</u></p>	
<p>75. Name of informant: <u>JOHN A. SMITH</u></p>		<p>76. Address of informant: <u>NEW YORK</u></p>	
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<p>79. Name of informant: <u>JOHN A. SMITH</u></p>		<p>80. Address of informant: <u>NEW YORK</u></p>	
<p>81. Name of informant: <u>JOHN A. SMITH</u></p>		<p>82. Address of informant: <u>NEW YORK</u></p>	
<p>83. Name of informant: <u>JOHN A. SMITH</u></p>		<p>84. Address of informant: <u>NEW YORK</u></p>	
<p>85. Name of informant: <u>JOHN A. SMITH</u></p>		<p>86. Address of informant: <u>NEW YORK</u></p>	
<p>87. Name of informant: <u>JOHN A. SMITH</u></p>		<p>88. Address of informant: <u>NEW YORK</u></p>	
<p>89. Name of informant: <u>JOHN A. SMITH</u></p>		<p>90. Address of informant: <u>NEW YORK</u></p>	
<p>91. Name of informant: <u>JOHN A. SMITH</u></p>		<p>92. Address of informant: <u>NEW YORK</u></p>	
<p>93. Name of informant: <u>JOHN A. SMITH</u></p>		<p>94. Address of informant: <u>NEW YORK</u></p>	
<p>95. Name of informant: <u>JOHN A. SMITH</u></p>		<p>96. Address of informant: <u>NEW YORK</u></p>	
<p>97. Name of informant: <u>JOHN A. SMITH</u></p>		<p>98. Address of informant: <u>NEW YORK</u></p>	
<p>99. Name of informant: <u>JOHN A. SMITH</u></p>		<p>100. Address of informant: <u>NEW YORK</u></p>	

3029

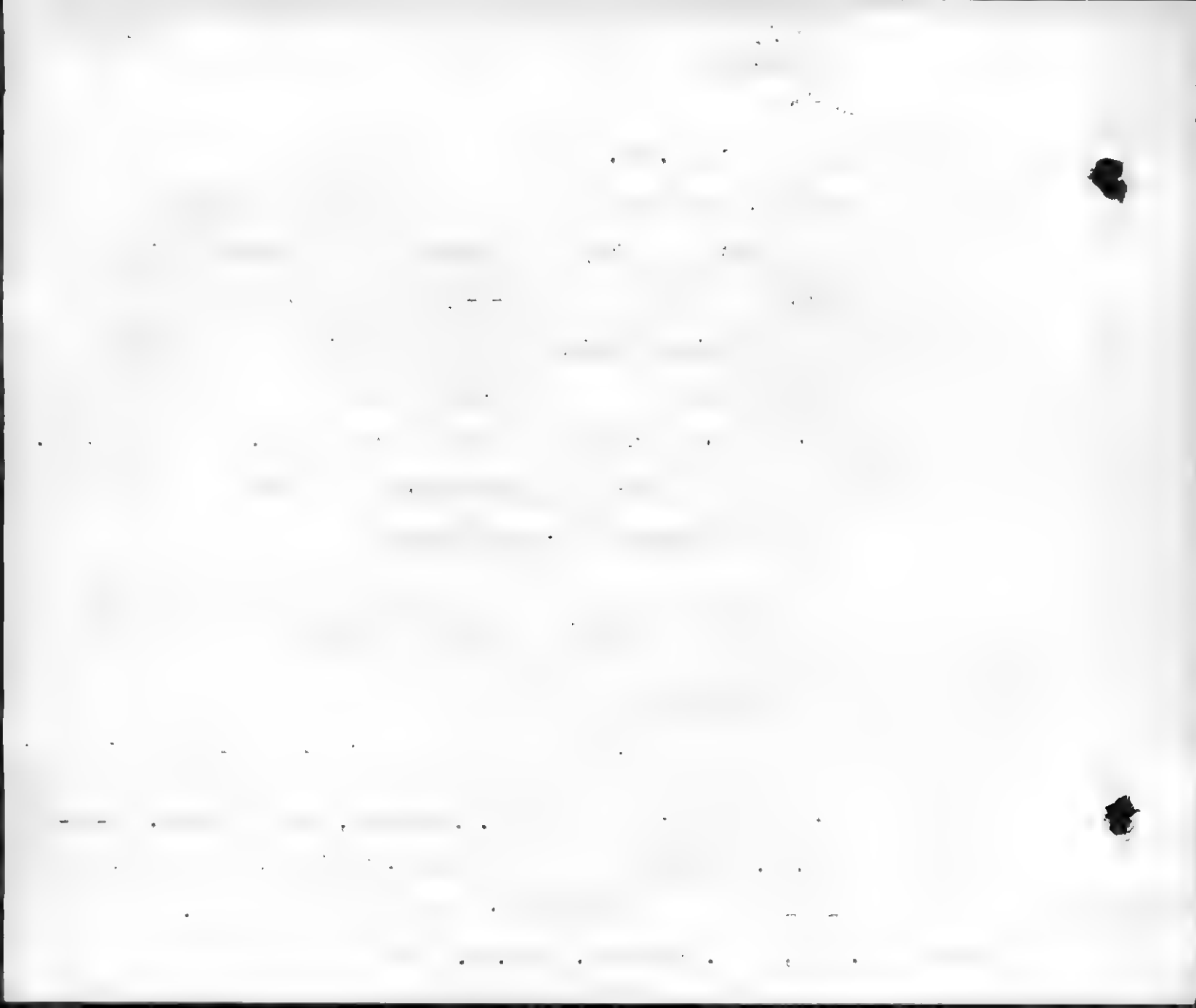
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 21yrs. 7mo. 11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2030 Druid Hill Avenue	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle (NMI) Last BURTON		4. DATE OF DEATH Month March Day 11 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-95
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY Private Family	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Burton		14. MOTHER'S MAIDEN NAME Carrie Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Informant Address Not obtainable Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease, severe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fibrosis of the myocardium DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized, severe			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28 , 19 37 , to March 11 , 19 59 and that death occurred at 8:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 3-12-59			
ACTUAL SIGNATURE <i>S. P. Lacerva</i> M.D.		23. FUNERAL DIRECTOR'S SIGNATURE S. P. LACERVA Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hensley Fun. Home, 578 W. Biddle St. Balto. Md.		24a. REC'D BY REGISTRAR MAR 16 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN North East		Life		X North East			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pratt Nursin. Home				STREET ADDRESS (If rural give location) RFD # 1			
3. NAME OF DECEASED (Type or Print) CORA BURNS CAMERON				4. DATE OF DEATH (Month) (Day) (Year) Mar 30 19 59			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct 28, 1885	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jonothan P. Burns				14. MOTHER'S MAIDEN NAME Margaret Terry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Murray H. Cameron		North East Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) CARDIOVASCULAR FAILURE				INTERVAL BETWEEN ONSET AND DEATH 5 MIN.			
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE				YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) GENERALIZED ARTERIO SCLEROSIS				YEARS			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. GLAUCOMA (BILATERAL) PROGRESSIVE HYPERTROPHIC ARTHRITIS DEFORMANT				YEARS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-23-1958, to 3-30-1959, that I last saw the deceased alive on 3-30-1959, and that death occurred at 5:58 A.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) NORTH EAST, Md.		DATE SIGNED 3-30-59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/2/59		NAME OF CEMETERY OR CREMATORY North East Cemetery		LOCATION (City, town, or county) North East, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS North East, Md.	
DATE APR 7 '59							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03017

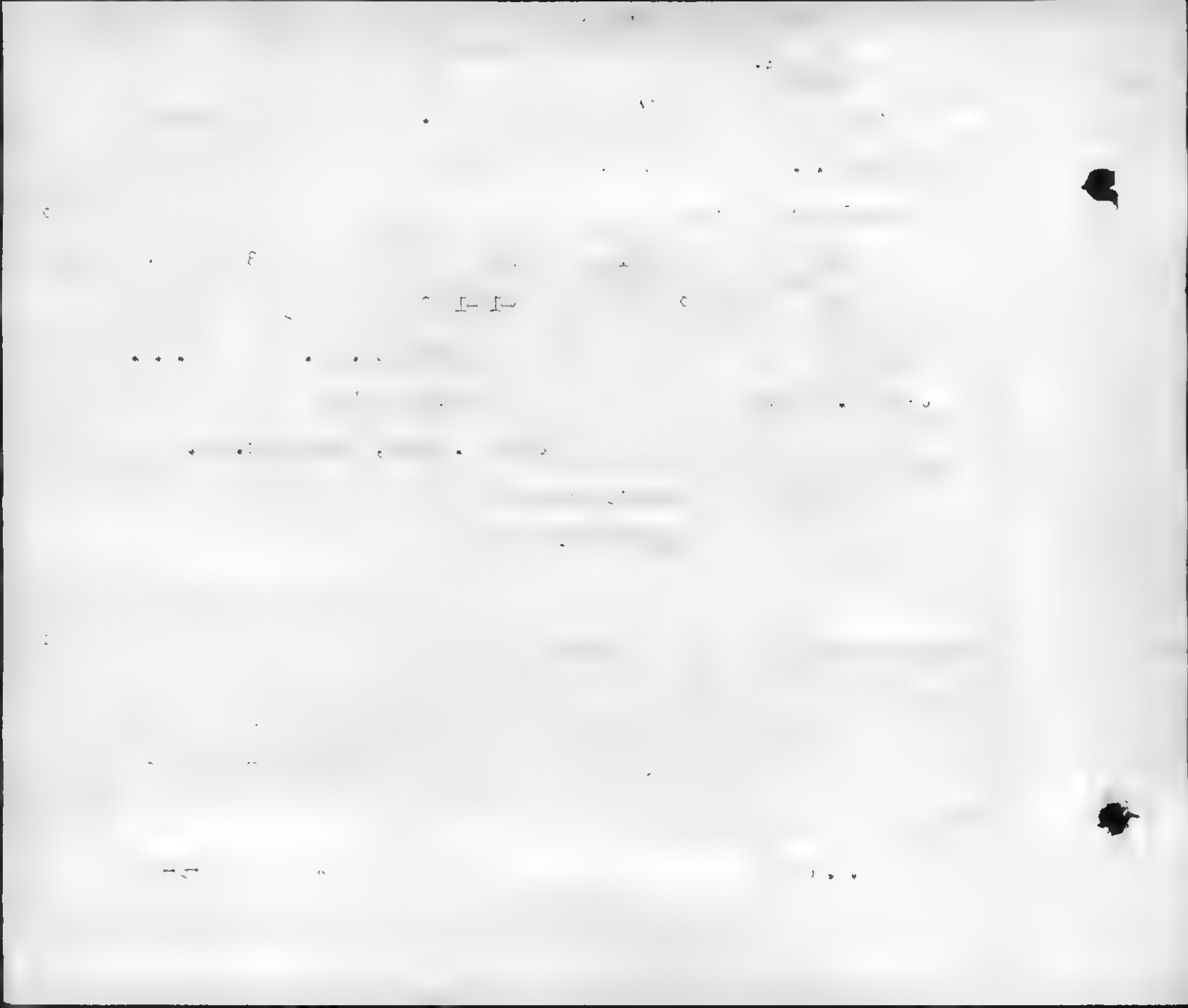
3031

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before adm'ssion) a. STATE Pa. b. COUNTY Chester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nottingham R.D.		c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Graybeal Nursing Home				d. STREET ADDRESS e. IS RECORD ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Anna Belle Clark			4. DATE OF DEATH Month 3 Day 4 Year 19 59			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 6-28-1873			9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Chester Co., Pa.			
11. BIRTHPLACE (State or foreign country) U.S.A.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James A. Criswell			14. MOTHER'S MAIDEN NAME Caoline Bailey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			
17. INFORMANT James O. Clark, North East. Md.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arterio sclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE R.C. Dodson			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson			DATE SIGNED 3-5-59			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORY Faggs Manor		
22d. LOCATION (City, town, or county) (State) Londonderry Township, Chester Co.		24a. REC'D BY REGISTRAR Mar 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans		
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun Md						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the file of death, or its designated agent, prior to burial, cremation, or removal, at removal, and return event within 72 hours after death.



3017

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 35 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle L. Last Croak		4. DATE OF DEATH Month March Day 7 Year 1959		5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1889		9. AGE (In years last birthday) 69 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elkton Supply Co.		10b. KIND OF BUSINESS OR INDUSTRY Building Material		11. BIRTHPLACE (State or foreign country) Towa		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Croak		14. MOTHER'S MAIDEN NAME Ellen Glass		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO 213-05-6164		17. INFORMANT Mrs. Dora M. Croak, Elkton, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Arterial DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH March 3		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from March 7, 1959 to March 7, 1959 , that I last saw the deceased alive on March 7, 1959 , and that death occurred at 7:00 P. M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) Elkton, Md.		DATE SIGNED March 7, 1959		ACTUAL SIGNATURE Dr. H. H. H. H.		PHYSICIAN'S NAME (Type) Dr. H. H. H. H.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 3/10/59		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAR 12 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. REGISTRAR'S SIGNATURE Arthur S. Kraus		24d. REGISTRAR'S SIGNATURE Arthur S. Kraus		24e. REGISTRAR'S SIGNATURE Arthur S. Kraus		24f. REGISTRAR'S SIGNATURE Arthur S. Kraus		24g. REGISTRAR'S SIGNATURE Arthur S. Kraus			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



3032

CERTIFICATE OF DEATH

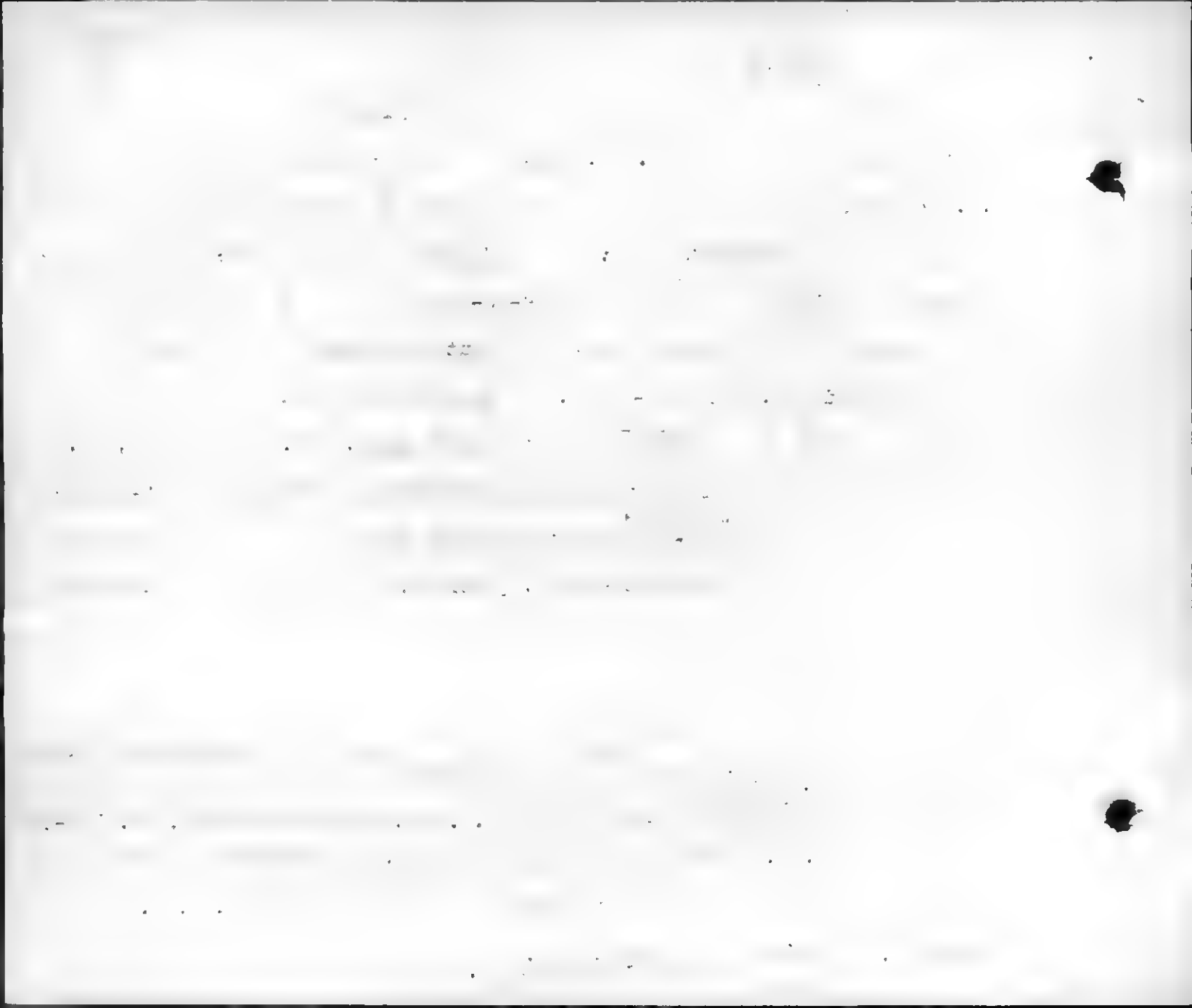
Reg. Dist. No. 96

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9yrs. 8mo. 14days		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital		d. STREET ADDRESS 429 Hamilton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVERETTE Middle HUBERT Last CROXTON		4. DATE OF DEATH Month March Day 9 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-26-1896	9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William L. Croxton - (Dec.)			14. MOTHER'S MAIDEN NAME Mary Cauthen (Dec.)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-03-3601		INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia right lower & middle lobes 420.0 DUE TO unresolved Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized					INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 7:00 a.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from June 23, 1949 , to March 9, 1959 , and that death occurred at 7:00 a. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>S. P. Lacerva</i>		DATE SIGNED 3-9-59			
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/11/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
22d. LOCATION (City, town, or county) Washington, D. C.					
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey		ADDRESS 8434 Georgia Ave. Silver Spring, Md.		24a. REC'D BY REGISTRAR MAR 11 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

1

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS 15 (4)
TSM 9/58



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03020

Reg. Dist. No.

3033

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE Del. b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. 4.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark	
c. LENGTH OF STAY IN 1b Visiting		d. STREET ADDRESS 349 E. Main	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George E. C. Davis		4. DATE OF DEATH 3 3 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting houses	
11. BIRTHPLACE (State or foreign country) Goldsborough, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William T. Davis		14. MOTHER'S MAIDEN NAME Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.1		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George E.C. Davis		Address Newark, De 1.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Thrombus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-4-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY White Clay Creek		22d. LOCATION (City, town, or county) (State) Newark, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE K.T. Jones		24a. REC'D BY REGISTRAR DATE MAR 10 '59	
ADDRESS Newark, Del		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03021

3034

Item 8 Filed 3-9-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>		d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1959</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 10, 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Inspector Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N & W</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Marion Davis</u>		14. MOTHER'S MAIDEN NAME <u>Nan Baker</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>-</u>		17. INFORMANT <u>Robert Roy Davis</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>Acute Coronary</u>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>March 4th, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-4-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Bristol Sullivan Co. Tenn</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Shaw</u> ADDRESS <u>North East, Md</u>		24a. REC'D BY REGISTRAR <u>March 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Shaw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



3018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena 148			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle P. Last DEMPSEY				4. DATE OF DEATH Month March Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October, 24, 1902	
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min 59		IF UNDER 24 HRS Months 2 Days 2 Hours 19 Min 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Galena, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry S. Dempsey				14. MOTHER'S MAIDEN NAME Winnie Walls			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 215-20-o888				17. INFORMANT Mr. Harry S. Dempsey, Address Galena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma testis DUE TO Carcinoma Rt Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB 18 , 19 58 , to March 2 , 19 59 ; that I last saw the deceased alive on March 3 , 19 59 , and that death occurred at 1:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Hospital, Elkton, Md. DATE SIGNED GLAUCO MARESCA, M.D. ACTUAL SIGNATURE GLAUCO MARESCA M.D. PHYSICIAN'S NAME (Type) GLAUCO MARESCA, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March, 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward D. Williams Address Millington, Md.				24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE Caring S. Fennell	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

04217

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Sec 1</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton (Rural) RD #3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>		d. STREET ADDRESS <u>IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
3 NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Lynn</u> Last <u>Dougherty</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1959</u>
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Howard Dougherty</u>		14 MOTHER'S MAIDEN NAME <u>Georgia Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Howard Dougherty, Elkton, Md. R.D.#3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature Infant (wt: 1 lb. 14 oz.) -</u> <u>769.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature delivery - mother with measles and Py. pyrexia</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 Hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>17 March 1959</u> to <u>17 March 1959</u> , that I last saw the deceased alive on <u>17 March 1959</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D.		DATE SIGNED <u>18 March 1959</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North East Methodist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>North East Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 1959</u>	
ADDRESS <u>1111 East, North East, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiser</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3035

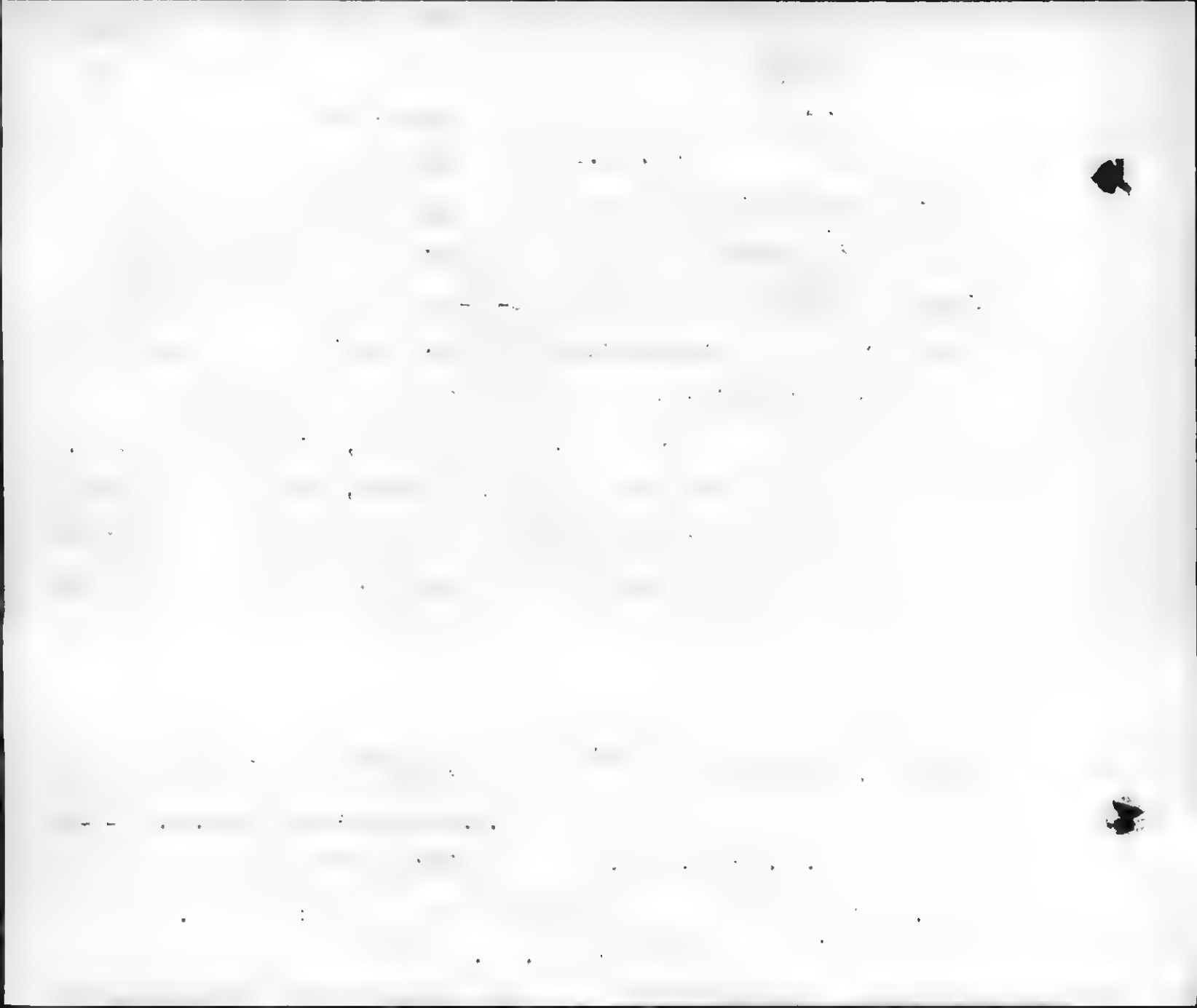
CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 32yrs. 5mo. 15days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 21st Street	
3. NAME OF DECEASED (Type or print) First Middle Last NESTER (NMI) GARIN		4. DATE OF DEATH Month Day Year March 28 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-88
9. AGE (in years last birthday) 70 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Not obtainable	
11. BIRTHPLACE (State or foreign country) Central America		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not obtainable from records		14. MOTHER'S MAIDEN NAME Not obtainable from records	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH unknown	
DUE TO Arteriosclerotic heart disease, severe			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial fibrosis		unknown	
DUE TO (c) Arteriosclerosis, generalized, severe		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 13, 1926 , to March 28, 1959 , and that death occurred at 8:20 a. m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 4-1-59	
PHYSICIAN'S NAME (Type) J. L. GAREY, M. D.		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 4/21/1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		24a. REC'D BY REGISTRAR APR 3 '59	
ADDRESS Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

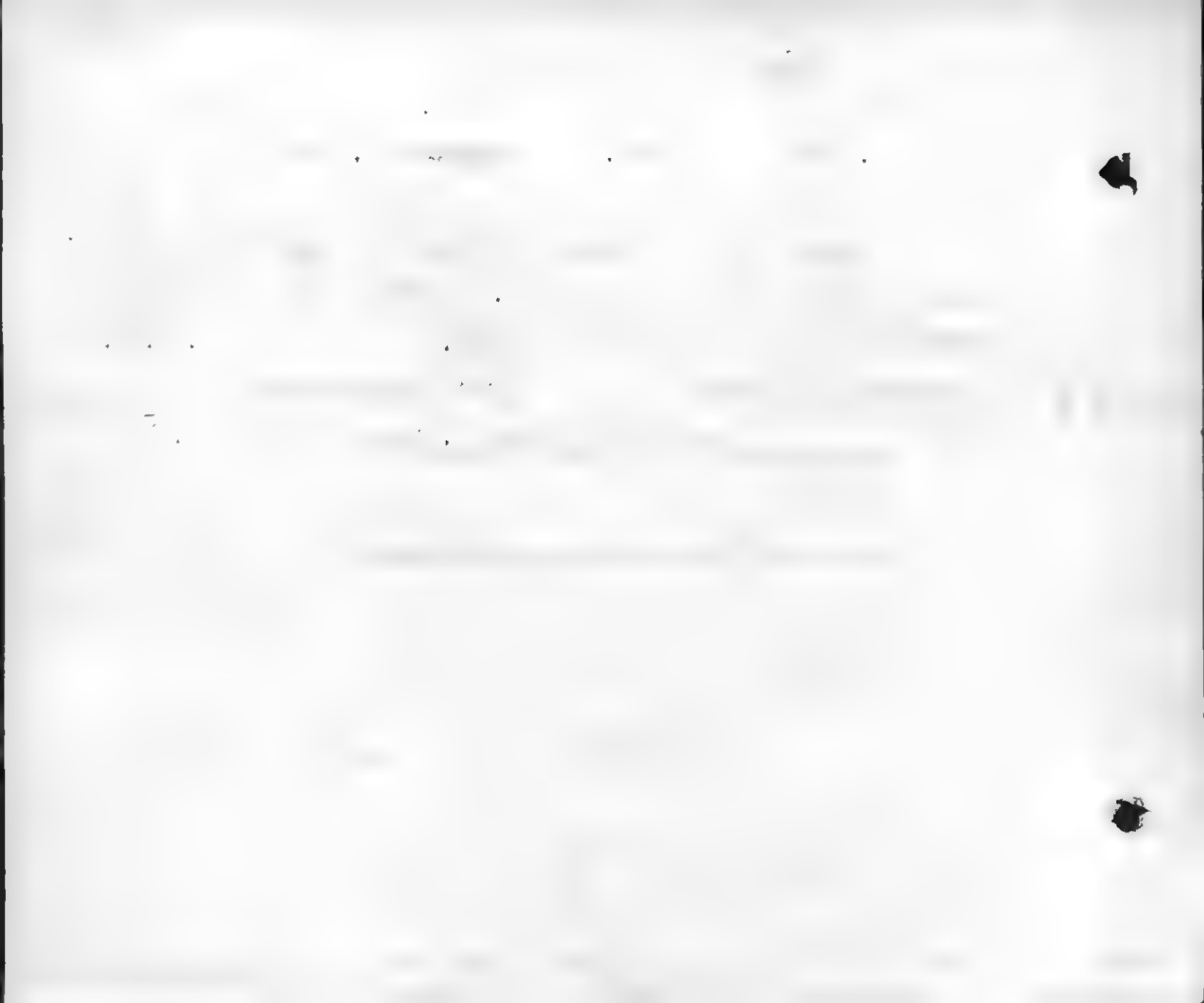
CERTIFICATE OF DEATH

Reg. Dist. No.

03024

3036

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora Md. Rural		c. LENGTH OF STAY IN 1b 48yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Olive Russell Gibson		4. DATE OF DEATH Month March Day 25 Year 59	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 1, 1885
9. AGE (In years birthday) yrs. 73		10. UNDER 1 YEAR Months Days Hours Min	11. UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Russell		14. MOTHER'S MAIDEN NAME Amilia Jane Harding	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 220-24-1207	
INFORMANT Edward L. Gibson		Address Colora Md. Rural	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Spine - Metastatic DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 yr			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 58 , to March 25 , 19 59 , that I last saw the deceased alive on March 21 , 19 59 , and that death occurred at Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Dudley Phillips M.D. Washington 2nd 3/26/59 PHYSICIAN'S NAME (Type) Dudley Phillips, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		3-28-1959	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Hopewell Cem.		Port Deposit Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Vernon E. M. Miller		ADDRESS Rising Sun Md.	
24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03025

3037

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Conowingo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>R. 10</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>W.</u> Last <u>Greer</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship building</u>	
11. BIRTHPLACE (State or foreign country) <u>Toliver N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilborn Greer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Prather</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-10-5080</u>	
17. INFORMANT <u>Ma Motine Greer - Conowingo Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Corrupt Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & Rheumatic C.V. disease</u> DUE TO (c) <u>2-3 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>14 med</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/31</u> 19 <u>57</u> to <u>March 27, 1959</u> , that I last saw the deceased alive on <u>March 3, 1959</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>Dudley Phillips</u> M.D. <u>Darlington Md</u> <u>3/28/59</u> SIGNATURE NAME (Type) <u>Dudley Phillips</u> <u>Darlington Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 31 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Bap. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Conowingo, Cecil Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 59</u>	24b. REGISTRAR'S SIGNATURE <u>Edna L. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3038

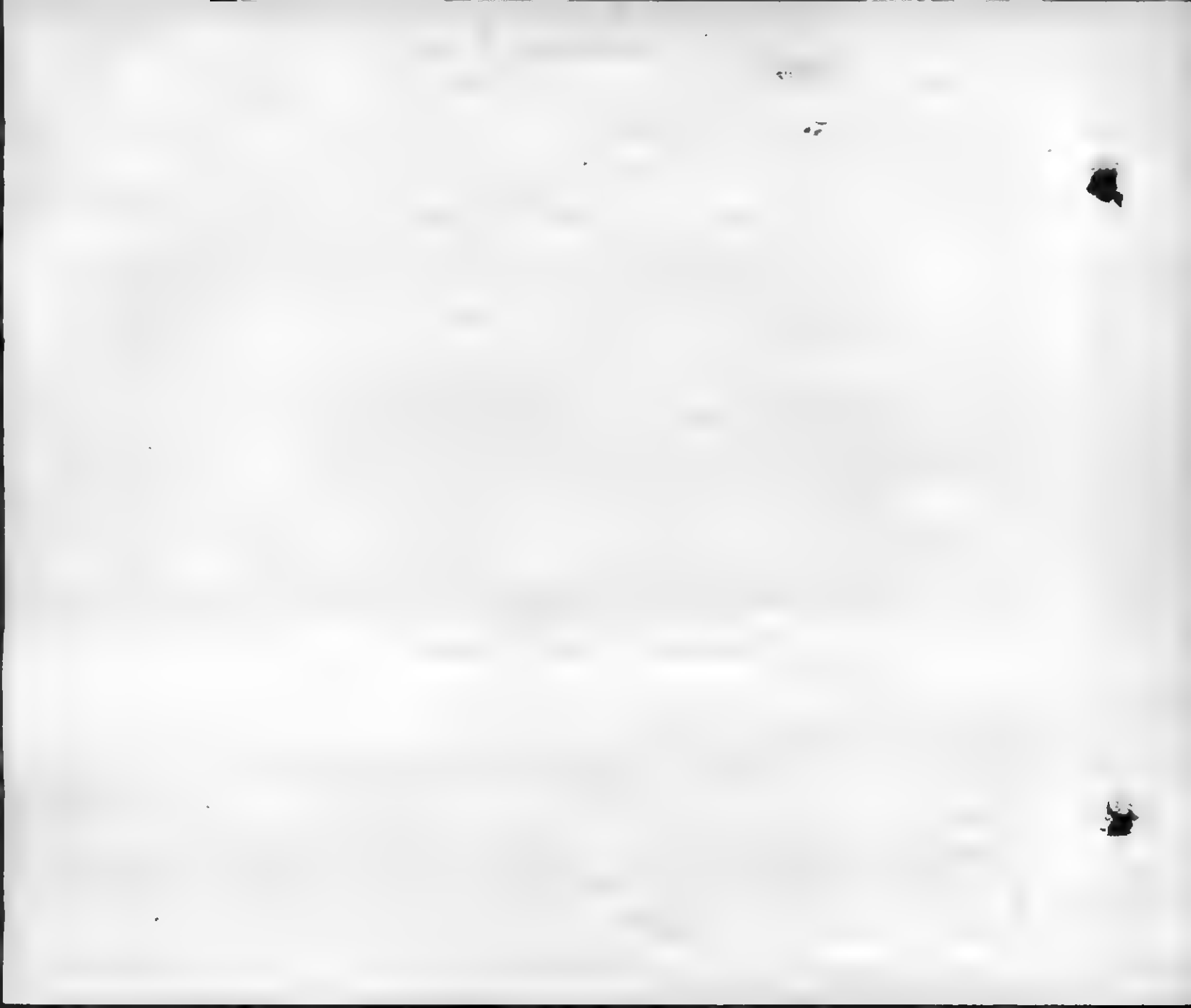
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D. 3</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Bettie Lawrence Harris</u>		4. DATE OF DEATH Month Day Year <u>March 16 19 59</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1938</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	
10a. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		10b. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
11. FATHER'S NAME <u>L.D. Lawrence</u>		12. MOTHER'S MAIDEN NAME <u>Tennie Lawrence</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		14. SOCIAL SECURITY NO <u>-----</u>	
15. INFORMANT <u>Mrs. Frank A. Stanley, Elkton, Md.</u>		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 3/4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		18b. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		18d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>59</u> , to <u>3-16-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>59</u> , and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Janet J. Greenwald</u> M.D. <u>202 E Main St Elkton</u>		DATE SIGNED <u>3/17/59</u>	
PHYSICIAN'S NAME (Type) <u>Janet J. Greenwald</u>		<u>202 E MAIN ST ELKTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>	22d. LOCATION (City, town, or county) (State)
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 File 9240 3-31-59 et

3039

CERTIFICATE OF DEATH

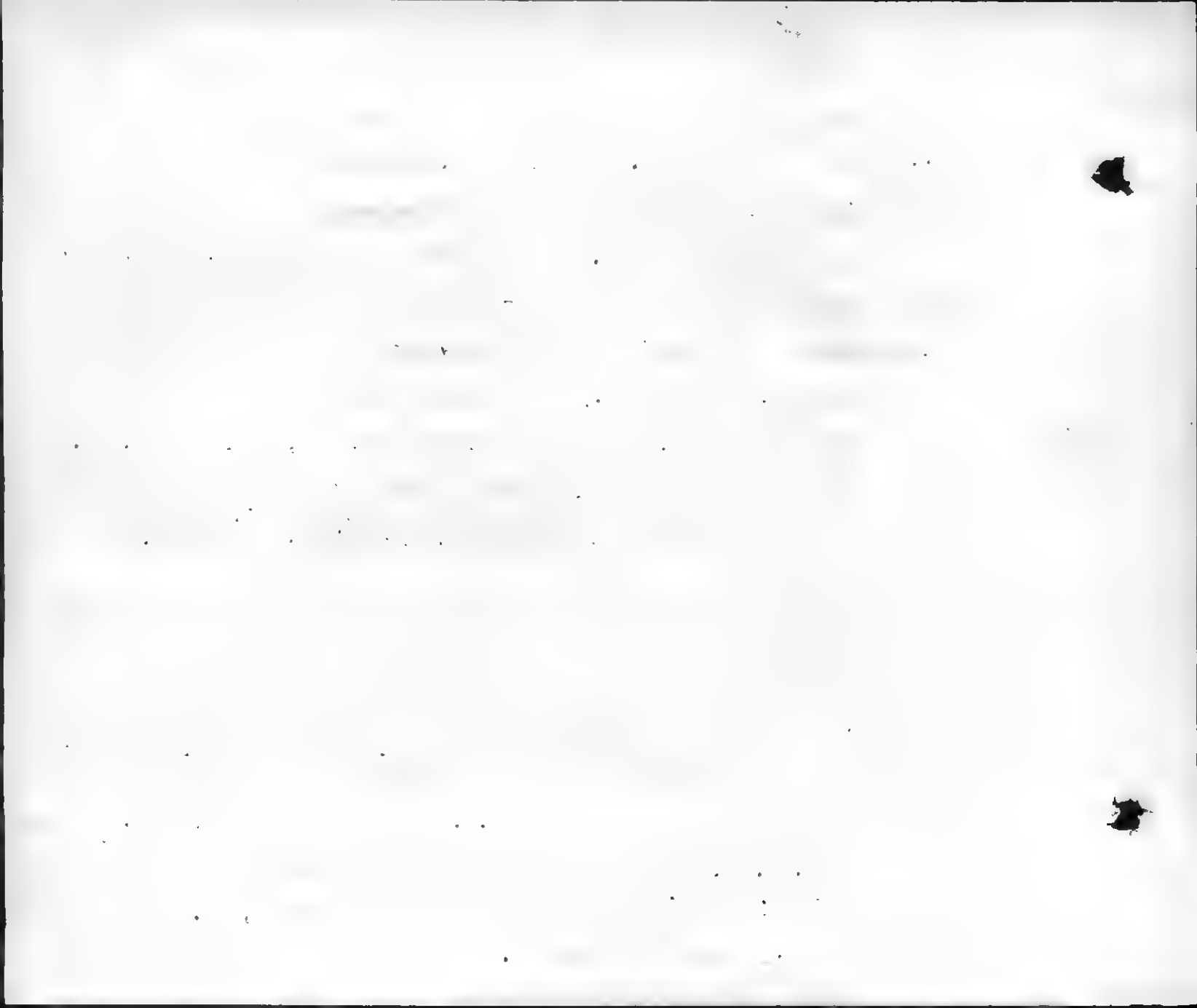
03027

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution on Residence before admission) a. STATE Maryland b. COUNTY Cumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 4 mo. 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 417 Magruder	
3. NAME OF DECEASED (Type or print) First Middle Last LEOLIA C. HART		4. DATE OF DEATH Month Day Year March 25 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-4-1910
9. AGE (In years last birthday) 48 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		10b. KIND OF BUSINESS OR INDUSTRY Medical	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thornton S. Cooper (dec.)		14. MOTHER'S MAIDEN NAME Eleanor Hansel	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 218-38-0791	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, adenocarcinoma of the right breast with metastases to the pleura, hilar lymph nodes, peritoneum, preaortic nodes and skin DUE TO (b) lymph nodes, peritoneum, preaortic nodes and skin DUE TO (c) unknown PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from October 26, 1958 to March 25, 1959 and that death occurred at 8:27a AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		DATE SIGNED 3-26-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3/26/59		22b. DATE THEREOF 3/26/59	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington B. Son		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
ADDRESS Havre de Grace, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur J. H...</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3040
CERTIFICATE OF DEATH

03028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Randalia Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle HOTRA Last				4. DATE OF DEATH Month March Day 8 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1887		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt.		10b. KIND OF BUSINESS OR INDUSTRY C & D Canal		11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hotra				14. MOTHER'S MAIDEN NAME Florence			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-2155A		17. INFORMANT Mrs. Alexander Hotra		Address Ches. City	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 424.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Taken to hospital following a minor accident - 3 days before death						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from June , 19 55 , to March 8 , 19 59 , that I last saw the deceased alive on March 2 , 19 59 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis M.D.				ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED 3/4/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/1959		22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery		22d. LOCATION (City, town, or county) (State) Ches. City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Pipin Funeral Home				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAR 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3041

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 43 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN HRADEC		4. DATE OF DEATH Month Day Year March 16 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Info		14. MOTHER'S MAIDEN NAME No Info	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO None	
17. INFORMANT Michael Hrabec		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RECTUM 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1953, to MARCH 16, 1959, that I last saw the deceased alive on MARCH 15, 1959, and that death occurred at 2:30 AM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Henry Davis M.D.		3/16/59	
PHYSICIAN'S NAME (Type) HENRY DAVIS		CHESAPEAKE CITY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 18, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Roses Cemetery	22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME Donald M. E. Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3042

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. COUNTY Maryland Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Craig Town		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Louise Jackson		4. DATE OF DEATH Month Day Year March 13 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1882
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Jackson		14. MOTHER'S MAIDEN NAME Mary Badders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Ray Jackson, Port Deposit, Md. R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Chronic Nephritis -		INTERVAL BETWEEN ONSET AND DEATH 6 mos -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Corneo-vascular Failure -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12 1959 to March 12 1959 that I last saw the deceased alive on March 12 1959 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit DATE SIGNED 3/13/59	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF 3-16-1959	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson		24a. REC'D BY REGISTRAR MAR 16 '59	
ADDRESS Perryville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3043
CERTIFICATE OF DEATH

Reg. Dist. No.

03031

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural c. LENGTH OF STAY IN 1b 32 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, Rural d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type as print) First Middle Last Frances Galatian Janney				4. DATE OF DEATH Month Day Year 3 4 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY 6		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Andrew Bedford Galatian				14. MOTHER'S MAIDEN NAME Mary James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John R. Janney Jr North E st R Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) North East				20g. (County) Cecil		20h. (State) Md	
21. I certify that I attended the deceased from June 1953 , to March 4, 1959 , that I last saw the deceased alive on 3-4-59 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. R. Janney				DATE SIGNED 3-4-59			
PHYSICIAN'S NAME (Type) W. R. Janney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-59		22c. NAME OF CEMETERY OR CREMATORY Bay View Methodist		22d. LOCATION (City, town, or county) (State) Bay View, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR MAR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

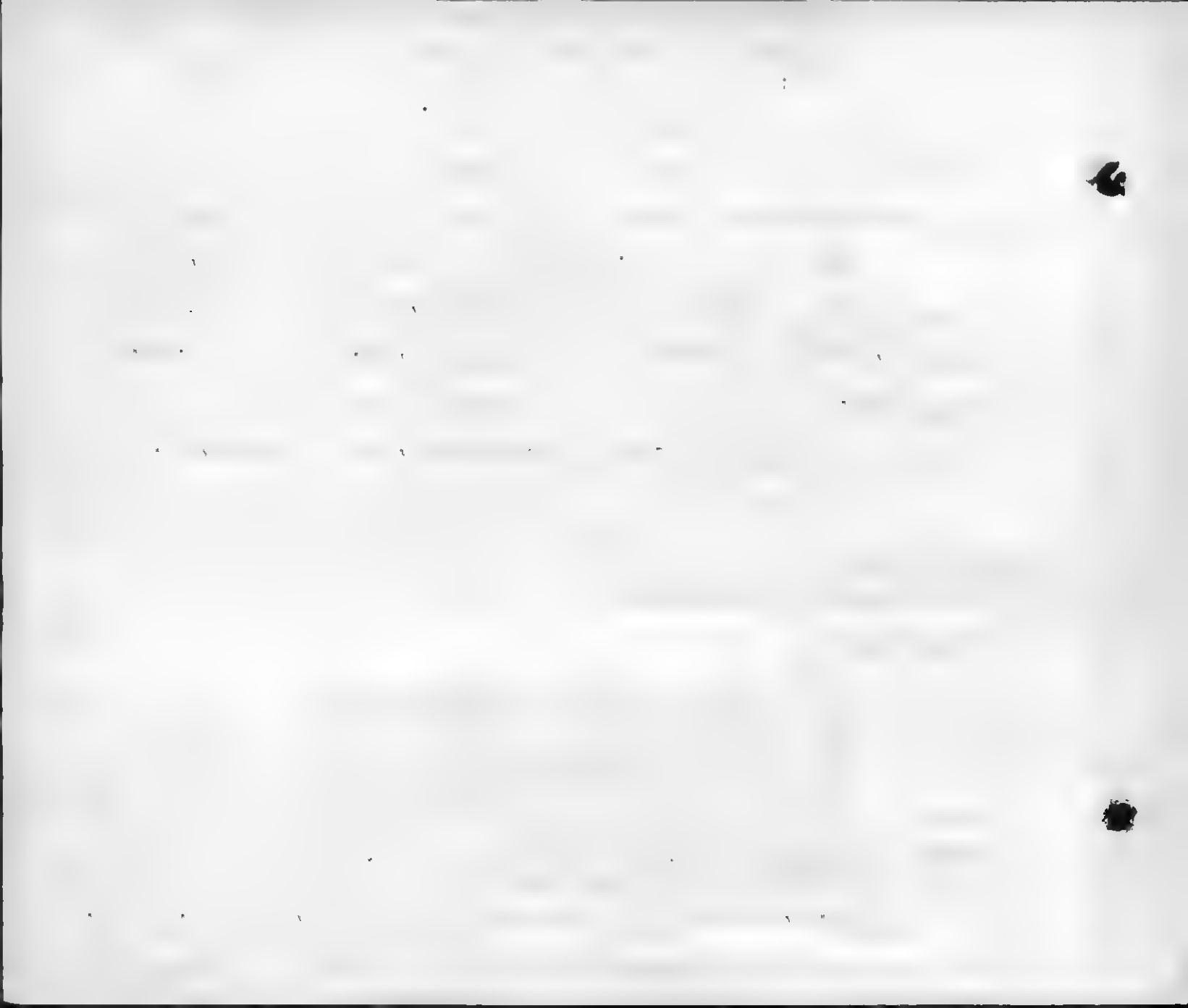
03032

3020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle J. Last MANN				4. DATE OF DEATH Month March Day 10 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 14, 1880		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter, General		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Mann.				14. MOTHER'S MAIDEN NAME Ludorna Grimes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 221-03-3885		17. INFORMANT Mrs. Alice Mann.		Address Cecilton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hours. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shock due to fall down stairs; Pneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7 Mar. , 19 59 , to 10 Mar. , 19 59 , that I last saw the deceased alive on 10 Mar. , 19 59 , and that death occurred at 5a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Chenshain M.D.				ADDRESS (Street, city or town, state) Cecilton, Md.		DATE SIGNED 11 Mar 59	
PHYSICIAN'S NAME (Type) Wallace Chenshain, D.O.				Cecilton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Flowers				ADDRESS Mellington, Md.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



CERTIFICATE OF DEATH

Reg. Dist. No.

03033

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARWICK</u>		c. LENGTH OF STAY IN 1b <u>14 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>J.</u> Last <u>MULLEN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 14 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>14</u> Hours <u>14</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOTIVE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN F. MULLEN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE CONNOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR II</u>		16. SOCIAL SECURITY NO. <u>221-05-305</u>	
17. INFORMANT <u>MARY ANDERSON</u>		Address <u>816 ADAMS ST. WILM DEL</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery Disease for past 2 years.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 24</u> , 19 <u>58</u> , to <u>Mar 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>59</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wallace Oberstein</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Cecilton, Md. 24 Mar 59</u>	
PHYSICIAN'S NAME (Type) <u>Wallace Oberstein</u>		Cecilton, d.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 30, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LAMBSON'S</u>	22d. LOCATION (City, town, or county) (State) <u>GALENA MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Piffner Funeral Home</u>		ADDRESS <u>Spom Co. Gladly Elkton</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03034

Reg. Dist. No.

3021

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cal</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>172 E. Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Pasada</u> Last <u>Pasada</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1923</u>
9. AGE (In years last birthday) <u>37</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas City Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Anaza</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Fernandez</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Juan Pasada</u>		Address <u>172 E. Main St. Elkton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Thrombo phlebitis of left Leb</u> [a], stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-13-59</u>	
22a. BURIAL CREMATION, 22b. DATE THEREOF Removal (Specify) <u>3/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park, Elkton, Md.</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>George E. Hicks, Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 to the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

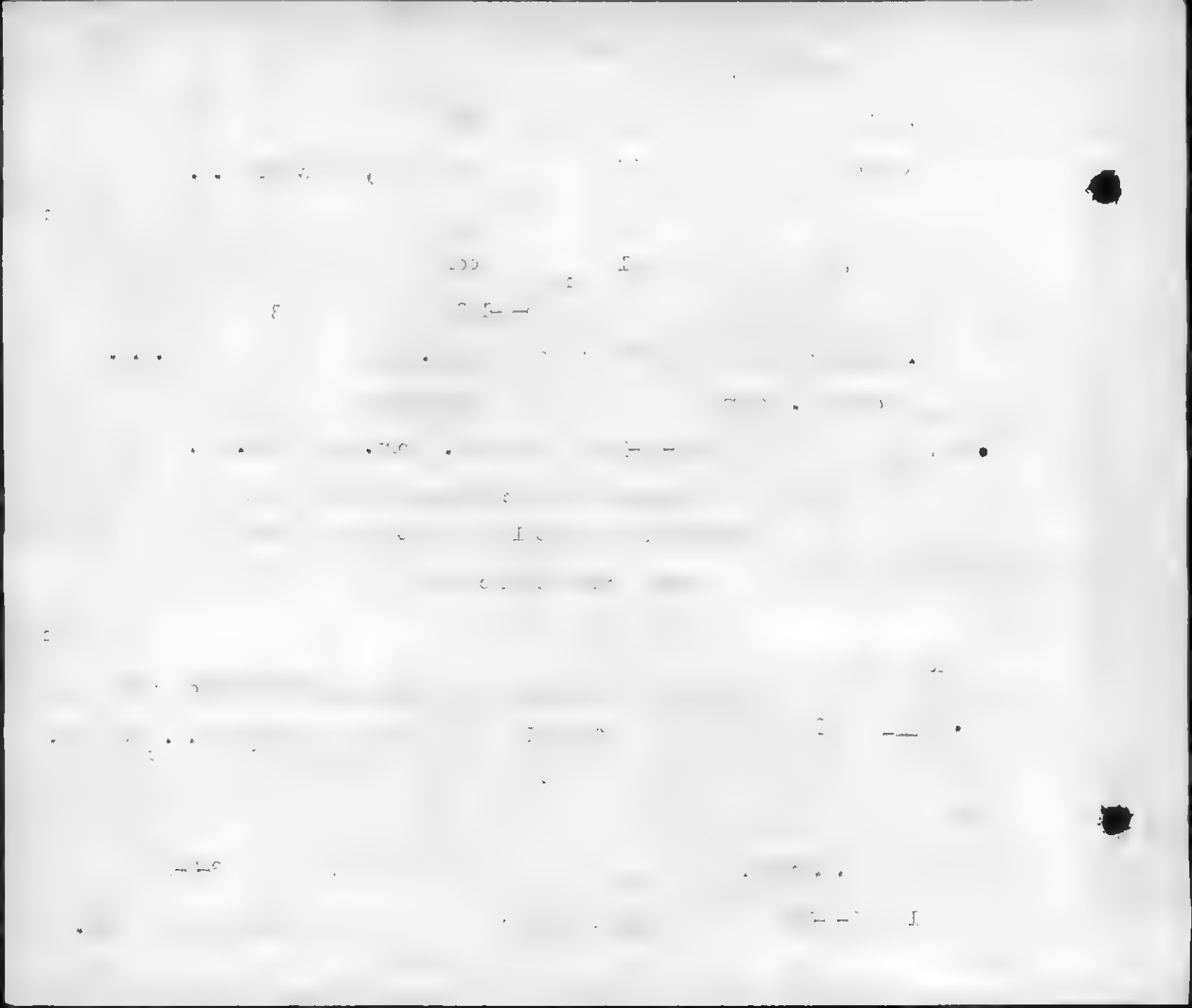
03035

3045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 3b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hacks Point, Earlville R.D.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Life					
3. NAME OF DECEASED (Type or print) First John Middle Earle Last Poore			4. DATE OF DEATH Month 3 Day 6 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1935		9. AGE (In years last birthday) 23 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. State Road		10b. KIND OF BUSINESS OR INDUSTRY Repairing roads		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George M. Poore		
14. MOTHER'S MAIDEN NAME Emma Craig			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Korean		
16. SOCIAL SECURITY NO. 214-34-3204			17. INFORMANT George M. Poore, Earlville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Torn left ear Fracture left temporal Bone at DUE TO Conditions, if any, which gave rise to immediate cause (b) junction of parietal and Fracture of right (c) frontal bone with laceration					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car ran off road and hit bank and threw him out of car					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Car ran off road and hit bank and threw him out of car			
20c. TIME OF INJURY Month, Day, Year 2:30 a.m. 3-6-1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> Route 213 Near Cecilton Cecilton R.D. Cecil Md.			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 213 Near Cecilton Cecilton R.D. Cecil Md.					
20f. (City or town) (County) (State) Cecilton Cecil Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 3-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-1959		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	
22d. LOCATION (City, town, or county) Cecilton Cecil Md.		22e. LOCATION (City, town, or county) (State) Cecilton Cecil Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward L. Hearn		24a. REC'D BY REGISTRAR DATE MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hearn	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

03036

Reg. Dist. No.

3046

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN It 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d STREET ADDRESS Cecil Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Sarah Middle E Last Rothermel				4. DATE OF DEATH Month March Day 18 Year 1950			
5. SEX Female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1867		9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Gonce				14. MOTHER'S MAIDEN NAME Susan Manning			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. J. Randolph Field		Address York, Penn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 4x0.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year. 5 yrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1958, to 18 March, 1959, that I last saw the deceased alive on 11 Nov. 1958, and that death occurred at 5:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner				ADDRESS (Street, city or town, state) No. 46 East Ave		DATE SIGNED 18 Mar. 4 '59	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/50		22c. NAME OF CEMETERY OR CREMATORY North East Met. Dist. Cemetery North East		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph O. Grant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

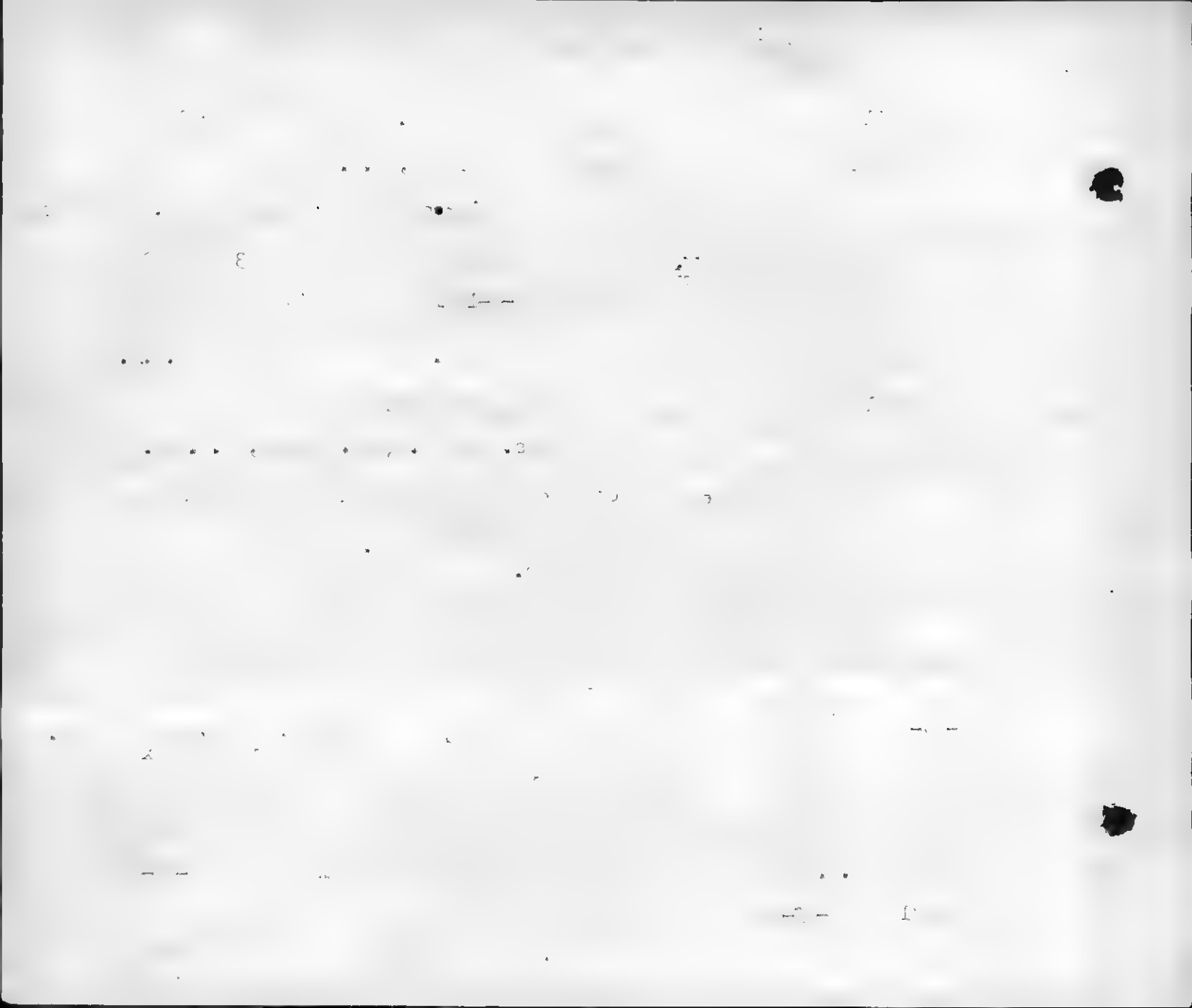
03037

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D.</u>	
c. LENGTH OF STAY IN 1b <u>8 hours</u>		d. STREET ADDRESS <u>Blue Ball Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>G</u> Last <u>Rugh</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emmuel Rugh</u>		14. MOTHER'S MAIDEN NAME <u>Clara Kuhns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Mrs. James G. Rugh, Elkton, R.D., Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock Fracture of Temporal bone left both lower legs</u> and left femur Laceration of scalp and face (b) <u>abrasions of face head and hands.</u> Haematoma in abdomen. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Was hit by a car on Road</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-55-59</u> <u>3</u> <u>22</u> <u>19 59</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 545</u>	20f. (City or town) (County) (State) <u>Elkton Cecil Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		DATE SIGNED <u>3-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be turned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6240 3-31-59 et

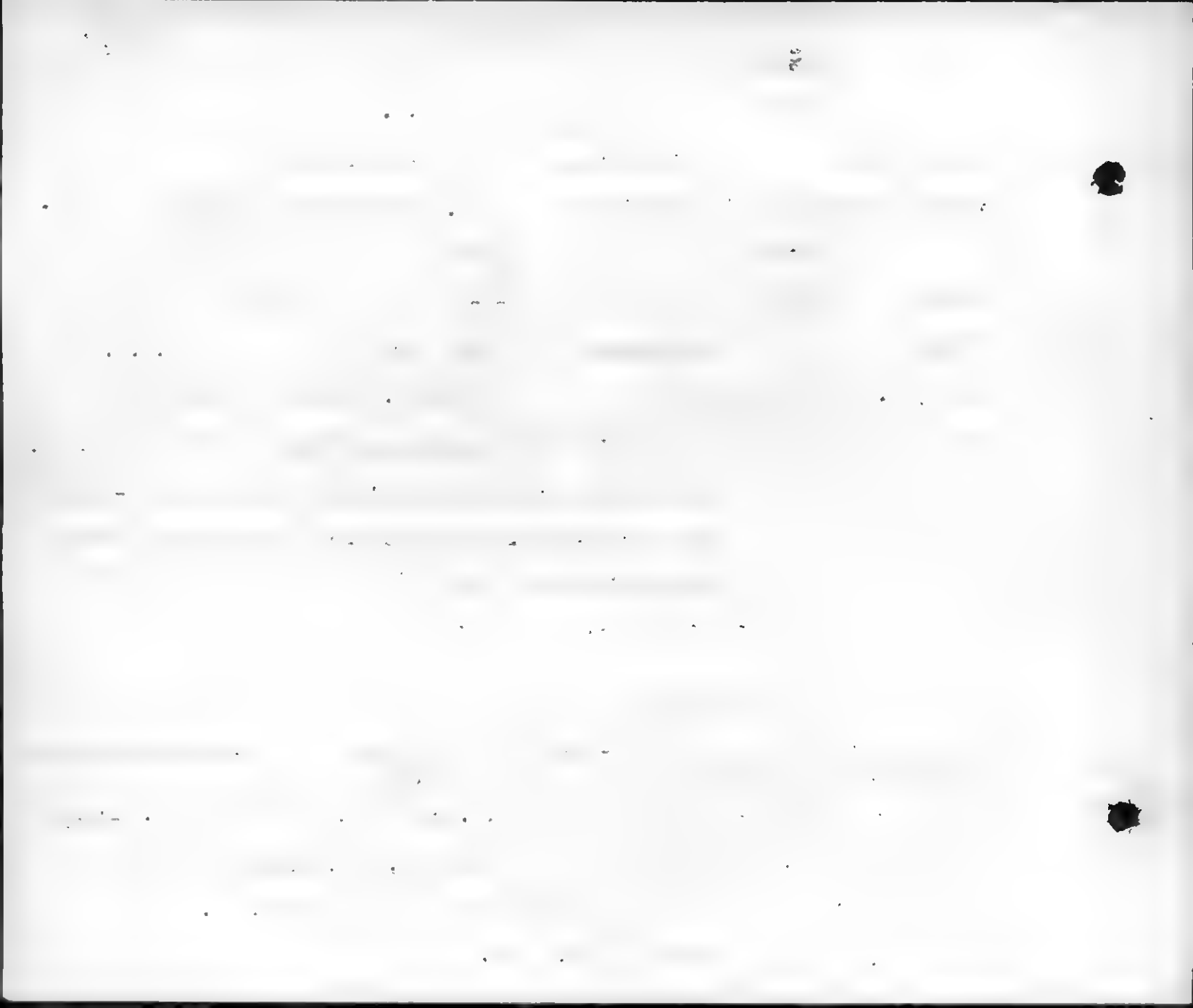
3047

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13038

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 5yrs 24days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE D.C. ? b. COUNTY Washington ? c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 478 d. STREET ADDRESS -Str-Elizabeths-Hospital- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marietta (NMI) Stevens		4. DATE OF DEATH Month 3 Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-73
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry S. Stevens (Deceased)		14. MOTHER'S MAIDEN NAME Julia W. Gregory (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes If yes, give war or dates of service WW I		16. SOCIAL SECURITY NO Not Ascertainable	
17. INFORMANT Hospital Records		Address VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia right middle & lower lobes DUE TO 15-18 days Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost (b) Abscesses multiple right middle & lower lobes DUE TO unknown (c) Broncho cutaneous sinus right DUE TO unknown		INTERVAL BETWEEN ONSET AND DEATH 15-18 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA offended the deceased from 2-12-54 , 19 to 3-8 , 19 59 and that death occurred at 2:00A , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 3-10-59	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Fort Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE MAR 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3023

03003

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 29, 1959</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BABY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS E. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. RANSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO <u>NONE</u>			
17. INFORMANT <u>THOMAS E. TAYLOR</u>				Address <u>FAIR HILL, RD. 4, ELKTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>MARCH 24, 1959</u> to <u>MARCH 30, 1959</u> , that I last saw the deceased alive on <u>MARCH 30, 1959</u> , and that death occurred at <u>5:30 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Henry V. Davis</u>				M.D. _____			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS M.D.</u>				<u>CHESEAPEAKE CITY MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/31/59</u>		<u>GALENA C.E.M.</u>		<u>GALENA MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows</u>				ADDRESS <u>Millington Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



3048

CERTIFICATE OF DEATH

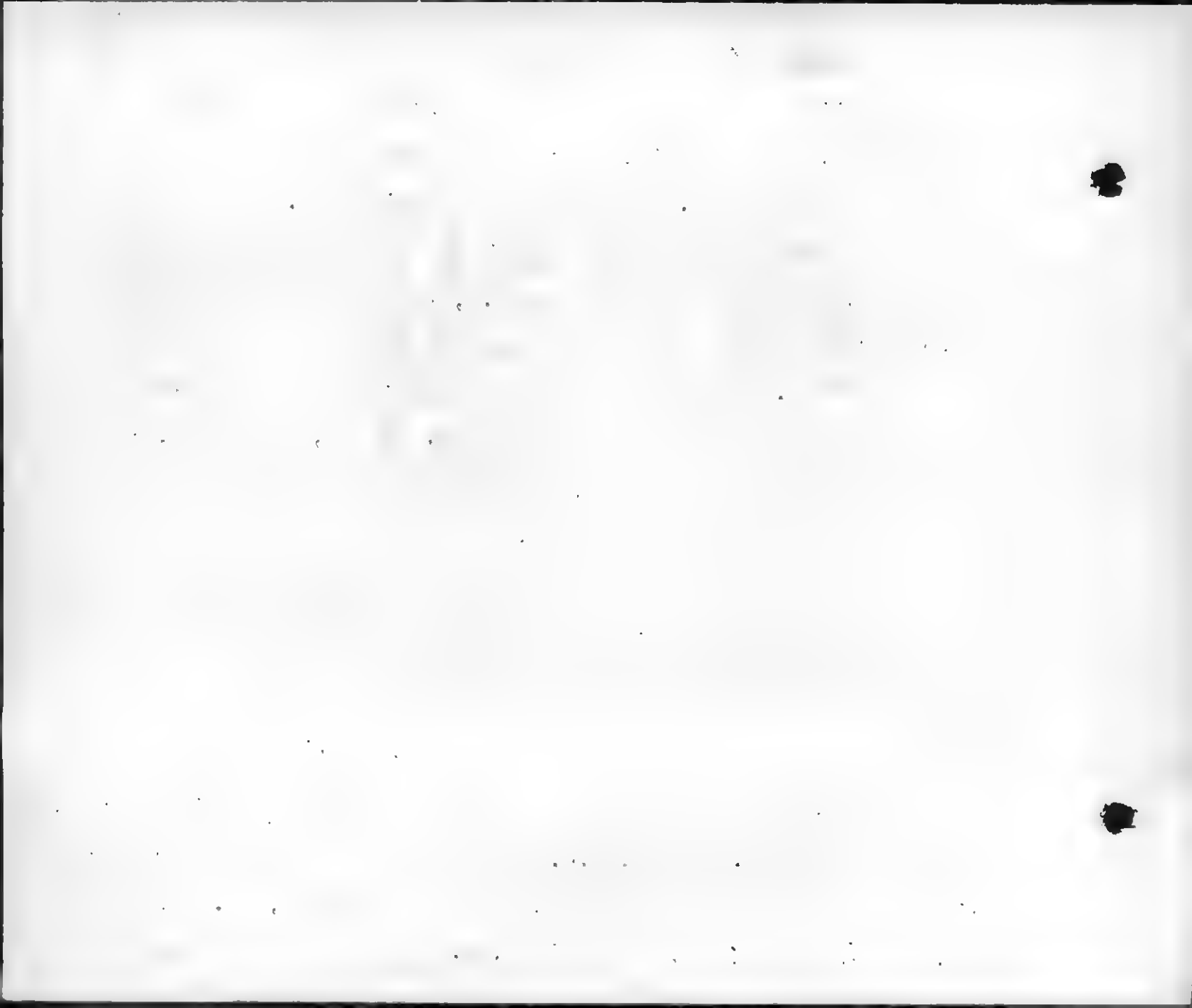
Reg. Dist. No.

03039

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aikin Ave.		d. STREET ADDRESS Aikin Ave.	
3. NAME OF DECEASED (Type or print) First Sallie Middle Nickle Last Taylor		4. DATE OF DEATH Month March Day 29 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1876
9. AGE (In years last birthday) 82 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank H. Nickle		14. MOTHER'S MAIDEN NAME Elizabeth Niblock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT William L. Taylor, Perryville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 354X DUE TO Causid ans, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterio Sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 2 months 82 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 70 19 58 to March 28 19 59 , that I last saw the deceased alive on March 28 19 59 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED March 31 1959	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL CREMATON, (Specify) Burial	22b. DATE THEREOF 4-1-1959	22c. NAME OF CEMETERY OR CREMATORY West Nottingham	22d. LOCATION (City, town, or county) (State) Colora, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Clarence I. Benson ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR APR 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3049

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY VIRGINIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 2309 N. Custis Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last WHITEHEAD		4. DATE OF DEATH Month March Day 1, Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 28, 1918
9. AGE (In years last birthday) yrs. 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank A. Whitehead	
14. MOTHER'S MAIDEN NAME Ida Brooks		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the lungs bilateral with wide-spread metastases to the abdominal organs and bone (c) and bone			INTERVAL BETWEEN ONSET AND DEATH 4-5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 7A o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from February 27, 1959 , to March 1, 1959 , and that death occurred at 1:25 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE S. P. LACERVA M.D.		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 3-2-59	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3/3/1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn	22d. LOCATION (City, town, or county) (State) Bluefield, West Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE PHILIP T. SCH		ADDRESS Havre DeGrace, Md.	24a. REC'D BY REGISTRAR DATE MAR 5 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with this registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

6025

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3050

CERTIFICATE OF DEATH

03041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION N. Main St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Henry Last Wilson		4. DATE OF DEATH Month 3 Day 18 Year 19 59	
5. SEX male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3- 20- 1883
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer		10b. KIND OF BUSINESS OR INDUSTRY Stationary Boiler. Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Filmore Wilson		14. MOTHER'S MAIDEN NAME Henrietta Norris Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-6047	
17. INFORMANT Elma N. Wilson, N. Main St. Port Deposit,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the Colon 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1 19 56 to 3/18 19 59 that I last saw the deceased alive on 3/18 19 59 and that death occurred at 8 A M, from the causes and on the date stated above. ACTUAL SIGNATURE Neil R. Taylor M.D. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 3/19/59 PHYSICIAN'S NAME (Type) Neil R. Taylor, M.D.			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 3-21-1959	
22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		22d. LOCATION (City, town, or county) (State) Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lea Patterson & Sons		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

